BEDSIDE MEDICINE FOR BEDSIDE DOCTORS

An Open Forum for brief discussions of the workaday problems of the bedside doctor. Suggestions of subjects for discussion invited.

MENTAL DISEASES IN THE ELDERLY

EDWARD W. TWITCHELL, M. D. (909 Hyde Street, San Francisco).—Since it is desirable in most cases of insanity in the elderly to keep the patient at home as long as possible, and as many of these patients may be kept at home throughout the rest of their lives, it is well that the general practitioner, who first comes in contact with them and who oftentimes cares for them to the end, should be able to recognize these mental states early and should know the best means of control of them.

Six or seven different varieties may generally be recognized, although no two authorities will agree when it comes to classification, but the following grouping is sufficient for all practical purposes.

1. Simple depressive states. 2. Chronic delusional states. 3. Acute and subacute delirious states. 4. Cerebral arteriosclerosis with psychosis. 5. Senile dementia of atrophic type. 6. Presbyophrenia. 7. Alzheimer's disease. The last two are considered by some to be practically identical.

1. The simple depressive states are those which frequently in women are called involutional melancholia. This is a disease which Kraepelin, although he originally admitted it, eventually rejected, feeling that in practically all instances it was simply a late manifestation of manic-depressive insanity. Others, however, feel that there are numerous instances of this late appearing depression in which the patients have never shown any cyclothymic trends during earlier life and therefore it should be regarded as being a distinct disease. This depression may be of the mildest or become of extreme severity. It may be of a few weeks' or months' duration and it may exist the rest of the life of the patient. Many of them will spend periods in sanatoria or state hospitals, and then come back home for a greater or lesser length of time. The danger of suicide is ever present. The treatment is essentially one of hygiene and nursing.

2. The chronic delusional states are oftentimes more difficult to manage. These patients, who are by some regarded as simply late appearing paranoids, become suspicious, fancy they are being spied upon, or poisoned or gassed, or conspired against. They protect themselves in all sorts of ways, such as changing locks on doors, pasting paper over keyholes, putting heavy blinds on windows, carefully scrutinizing all the food they eat, and withdrawing themselves from the society of those whom they suspect. Sometimes a delusion will be one of jealousy and the object of the jealousy will be made miserable by the patient. In this way they become what the French designate *persecuteurs persecutés*. This condition often makes it impossible for the patient to adjust himself to life outside of an institution. It is conceivable that such patients may be extremely dangerous when protecting themselves against the supposed machinations of their persecutors.

3. The acute and subacute delirious states are apt to have a rapid onset. Women seem to be more often afflicted than men and the time of appearance is frequently in the sixth decade, although it may appear ten years earlier. After a period of uneasiness, delusional ideas appear, followed soon by hallucinations of sight and hearing. Patients soon get into a state of excitement. This excitement makes them difficult of restraint and they have to be transferred to sanatoria or state hospitals. They will bite, scratch, strike those about them in their effort to free themselves from control. They will sometimes tear their own hair or beat themselves in their desperation. The picture gets wilder and wilder and a fever develops, sometimes rising to 106 degrees or 107 degrees. With this fever and rapid pulse and excitement, there is more or less complete lack of sleep. The patient rapidly gets into a condition of exhaustion and in a few weeks is brought to a state of collapse, and death soon follows. Sometimes an infection may be demonstrated intravitam. At other times while one takes it for granted, it is not demonstrable. Pathologic findings are variable; sometimes there is simply a considerable degree of hyperemia of the meninges and the brain, in other cases extensive destruction of nerve tissue has been demonstrated. This type of case was formerly often known as acute delirium. It is not only found in the presenium but also occasionally in those of more advanced age, say, in the late sixties. The mortality rate of these cases is high. While some patients go on to a condition of permanent mental deterioration and some few recover, the most of them die. There are a number of varieties and subvarieties which in a general way answer the above description, but the important point is that they come on relatively rapidly, run an extremely stormy course, with the wildest sort of delusions and hallucinations and generally end fatally.

4. Cerebral arteriosclerosis commonly accompanies advancing years, but it does not invariably do so. While many of the mental conditions found in the elderly are due to arteriosclerosis, by

no means are all of them. Cerebral arteriosclerosis is usually described as being of two types: A. Small vessel type; B. Large vessel type. In the small vessel type, the patient begins by showing the usual signs of senile mental deterioration, that is to say, failure in memory, increasing fatigability for mental work, impaired judgment, attacks of drowsiness, headaches, dizziness, character changes of greater or less importance, transitory monoplegias, or hemiplegias, disturbances of speech, epileptiform attacks, etc. The condition creeps on gradually but is apt to be marked by sudden aggravations, the patient recovering always at a lower level than he was prior to his attack. All symptoms increase in severity and it is characteristic that certain faculties may suffer considerably, while others will be relatively unimpaired. In other words, the involvement is a patchy one. This clinically makes the condition distinguishable from general paresis where the psyche is involved as a whole. In these cases, as the patient gradually gets feebler and feebler, death may come without any striking occurrences. The patient simply grows a little bit feebler, a little more deteriorated mentally, finally dropping off to sleep permanently. In the large vessel type of involvement, the disease will begin, say, by hemiplegia, leaving the patient more or less crippled thereafter physically and with greater or less amount of mental deterioration. If aphasia is associated, the plight of the patient is worse than if aphasia is absent. Death may come suddenly as the result of a second, third or fourth stroke. Cerebral arteriosclerosis cannot always be postulated from the condition of peripheral vessels. Excellent radials may exist in conjunction with very chalky cerebral vessels. The retinal vessels give a far better index as to the brain vessels than do any other accessible arteries. A great proportion of these patients can be kept at home during the entire course of the disease, the greatest difficulty being the management of those patients who are rendered helpless by paralysis. The mental condition may be sometimes a stormy one and many of these patients are as violent as any manic. Generally, however, the difficulty consists in their inability to take care of themselves, in their tendency to lose themselves in their own homes, to wander around at night, to get out of the house and get lost in the streets, and so on. Toward the end, much difficulty is encountered in the care of those who are incontinent of urine and feces and they become very trying patients from a nursing standpoint.

5. The simple atrophic type of senile dementia begins very much in the same way that the arteriosclerotic does, but it has none of the focal manifestations which always serve to differentiate the arteriosclerotic disease from another. Here the condition is apt to be simply an increasing quantitative lowering of the intelligence, until finally the patient ends, "sans teeth, sans eyes, sans taste, sans everything." The pathologic findings differ from the arteriosclerotic ones in that the vascular changes which are so characteristic of arteriosclerosis are lacking. Instead there is merely an atrophic state, the vessels being in relatively good condition.

6. Presbyophrenia. This is a condition about which there is much discussion. The name was originally used by Kahlbaum. Wernicke developed the idea and many psychiatrists since have described the disease as a definite entity, but as Bleuler says, the description of one author is quite different from that of another and the same author, writing at different periods, describes two different things. Kraepelin says that most patients are over seventy years of age and yet authors will agree that cases are to be encountered as early as the forties. A striking thing about all presbyophrenics is the peculiar conservation of certain abilities, with a very marked loss of others. For example: a patient may be able to converse rather entertainingly, and to the superficial observer may not be noticeably abnormal, but may all the while be completely disoriented and have no real appreciation of his surroundings. The chatty old gentleman toward the end of the conversation asks you if you are, by any possibility, Benjamin Franklin, or will tell you that he is sixty years of age and that he has two sons who are seventy-five. Memory defects are common and it is due to this that many assume the disease to be identical with Korsakow's, although a toxic factor and neuritis will be entirely lacking. Certainly, while in some respects the disease picture may resemble Korsakow's, there is no excuse for confounding it with a real Korsakow, which must have a toxic polyneuritis as basis of the picture. One thing is apt to be noticeable about these patients and that is that they are generally free from depression. As a rule, depression is a part of the picture of most presenile and senile psychosis. The presbyophrenic, however, is noticeable for his contentment. The presbyophrenic, in many instances, may be kept at home if there is anybody to look out for him at all. He simply needs nursemaid care.

7. Alzheimer's disease. This is another disease, concerning which there has been much controversy. With reason, Bleuler calls this identical with presbyophrenia. Like presbyophrenia, it may start in the forties; however, it may not appear until the late sixties or seventies. It is, however, apt to proceed pretty rapidly to a very complete dementia and practically all authors insist upon the speech disturbances. In the well advanced case, the speech may consist of constantly repeated phrases, groups of words, or inarticulate sounds. Death may follow within a few years after the onset. The pathologic findings as described by Alzheimer are an enormous destruction of cortical cells with peculiar bundles of fibrinous material. These patients often get rapidly to such a point that home care is impossible.

One difficulty with the mental conditions of advanced years is the reluctance on the part of state institutions to receive such patients. The attitude of the state hospitals is that all ordinary cases of senile dementia should be kept in the counties in which they originated and in many instances where such patients have been committed, they have been returned to their homes after the condition was definitely determined by examination at the hospital to which they had been committed. Generally such patients can be treated in relief homes, where the families are not able to pay for care in some private institution, or employ adequate nursing at home. In many instances, however, it means that some devoted daughter or sister must sacrifice herself for a period of anywhere from six months to as many years.

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AARON J. ROSANOFF, M. D. (1930 Wilshire Boulevard, Los Angeles).—When a mental disorder in an elderly person first comes to medical attention, an investigation should at once be instituted with a view to determining the exact diagnosis, pathology, and prognosis, as a basis for a plan of management and treatment. It has already been pointed out in Doctor Twitchell's opening paper that in many instances a mental disorder not peculiar to senility happens to occur in an elderly person. In such cases there are no special therapeutic indications. The cases are handled approximately in the same manner as those observed in younger persons.

In the cases presenting mental disorders which are more or less peculiar to advanced ages, such as senile dementia, cerebral arteriosclerosis, Alzheimer's disease, and involutional melancholia, the physician is confronted with some practical issues.

Perhaps the first question that has to be dealt with is that of the amount of custody and supervision which the patient requires. In cases manifested by excitement, violent and aggressive tendencies, or by suicidal impulses, or by noisy or destructive behavior, institutional care should as a rule be arranged. Whether it is to be care in a public institution or in a private sanatorium depends mainly on the financial resources of the patient or his relatives.

It is, of course, also possible even in such a case to avoid placement in an institution by making elaborate arrangements for care in a secluded place with day and night nurses, but such arrangements are very expensive and present no real advantage.

Patients who are free from violent or dangerous tendencies can be cared for in a private home indefinitely, although they, too, require, of course, a certain amount of supervision.

A second practical problem that presents itself sooner or later in the great majority of cases arises out of physical disabilities with which mental disorders of elderly people are often associated. The patients become bedridden, have to be dressed, undressed, bathed, fed; they also often soil or wet their clothing or bedding, either from loss of sphincter control or from mental deterioration or both. In such cases there is much danger of the development of bedsores and of a complicating fatal bronchopneumonia. The latter may be produced either by inspiration of food in cases of partial paralysis of the mechanism of deglutition, or it may occur as a hypostatic affair, or from exposure to cold acting upon a weakened resistance.

This problem is to be met by organizing efficient nursing. To do so in a private home usually imposes months or even years of strain upon any person undertaking to care for such a case. In my opinion the advice to the family in such a case should again be in favor of public or private institutional care. Such advice is in the interest not only of relieving near relatives of an abnormal burden, but also of securing for the patient a better organized and more skillful nursing care.

A third practical problem is that of arranging for a winding up of the patient's affairs in anticipation of the physical disability and the mental deterioration which is to be expected in most cases of mental disorders peculiar to senility.

For example, as soon as a diagnosis of cerebral arteriosclerosis has been made, and while the patient is still legally competent, the relatives should be made fully aware of his condition and of the prognosis, retirement from business should be insisted on, as well as the making out of a will, etc.

These, of course, are delicate matters to broach to patients, and the physician can help a great deal by his participation in a tactful handling of them.

Recoverable cases of mental disorder occurring in elderly people are, of course, to be managed in a very different way; but, as has already been stated, these are not the cases peculiar to senility and present no special indications merely by reason of having occurred in an elderly person.

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SYDNEY KINNEAR SMITH, M. D. (230 Grand Avenue, Oakland).—It would seem that our most constructive work as physicians in handling problems of senile change would lie more especially in the prophylactic field. Obviously the curative aspect is not hopeful, other than in a symptomatic procedure. When senility has set in, both physical and mental, the problem is essentially one of custodial care in one form or another. It is impossible, of course, to say at what point old age begins, and, as a matter of fact, is not particularly important. If we are to consider the handling of old age problems we must anticipate this period and make our plans accordingly. We

all see individuals in the period from fifty to sixty who are capable of performing all the functions of life with regularity, but who are incapable of meeting the stresses of life in the way that they did in years past. It is at this period that we should lay definite plans looking toward a physically and emotionally satisfactory old age. Naturally, there is a great individual difference in the mode of onset of symptoms of decline, depending on previous habits of life, as well as individual peculiarities and hereditary predisposition. Individuals, at a time when their judgment is yet sufficiently reliable, should be aided in planning the years to come. Moderation in all activities should be the keynote of procedure and the expenditure of unnecessary energy be avoided. With most individuals past middle life there is less physical, emotional and intellectual drive. Cares and anxieties which formerly were easily overcome now become unbearable. Intellectual endeavor which previously was not attended by undue fatigue, now is followed by languor. Also physical effort is accompanied by a new weariness.

Our council should be, therefore, against undue anxiety during this presenile period. New undertakings involving large financial responsibilities should be avoided. Involvement in legal procedures is a strain that takes a large toll in this period and should be avoided if possible.

The pressure of social duties should be minimized, the strain of "late hours," large gatherings, indigestible food at late hours should be properly regulated.

Sleep is a problem of the senile and presenile period that should be most carefully considered. The tendency is toward shorter hours of sleep and to wakefulness. Unfortunately the body at this age is needful rather of more than of less sleep. Consequently it should be our aim, medically, to bring about conditions conducive of sleep. We may well employ prolonged neutral baths before retiring, sedative drinks, and occasionally mild sedatives. Above all we should insure physical relaxation in the hours preceding retirement.

In pursuance of our aim of bringing about moderation, we should aim at a rather definite plan of daily activity, including reasonable amount of exercise, rest, recreation, etc. Probably in this connection one of our outstanding efforts should be in the development of a hobby. We might almost consider the old person without a hobby as a hopeless problem. By inculcating a real interest in the presenile period we may avoid the later resort to the childish procedures often introduced in the senile program of trivial manual pursuits. Many practical suggestions in this regard may be found in Dr. Lillian Martin's recent book on the subject of Old Age.

Our effort in these comments is to urge a farsighted consideration of senile problems, beginning in the presenile period, rather than waiting for the hopelessness of senile dementia. We do not mean to suggest that the result of senile and arteriosclerotic changes in the brain can be overcome, but we do suggest that with reasonable planning the manifestations of these changes may be minimized and the individual made a much more agreeable person for himself and for others to live with.

A Cash Incentive to Broader Public Relations.—The Board of Trustees, impressed with the activities of the Committee on Publicity of the Philadelphia County Medical Society and the determination of the Committee on Public Relations of the State Society to make the year 1932 a banner year in the development of a better understanding by the people of Pennsylvania of the purposes of our organized medical profession, have evolved a plan for participation by the State Society in the endeavors of wide-awake county societies to develop closer contacts with the community health and sickness problems in their respective counties.

The reasons for such stimulation, the source, character, and method of imparting such knowledge to the public and the process by which approval may be expressed in terms of financial assistance, are all set forth in the accompanying resolution adopted by the Board of Trustees at their meeting December 8, 1931. The chief aim in this action by the Board of Trustees is encouragement to even the smallest of our active county societies in all efforts to convince the people of their respective counties that the local medical profession is progressive, unselfish, and capable of and willing to assume leadership in all community activities pertaining to sickness prevention.

Resolution:

Whereas, It is believed that the public relations activities of certain of our component county societies by means of authoritative and properly censored articles in the public press and over the radio, extend their benefits to the public and redound to the credit of physicians in certain surrounding counties; and

Whereas, It is believed that the State Society can best advance the relations of its members with the public throughout the state by offering financial assistance as well as educational leadership to the component societies which have developed a proper interest in such work; and

Whereas, The expense of carrying on such activities varies in the different county societies; therefore be it

Resolved, That the Board of Trustees of the Medical Society of the State of Pennsylvania approve the reimbursement to such component societies of such expense, on recommendation to the Board by the Public Relations Committee of the Medical Society of the State of Pennsylvania, to an amount not to exceed fifty cents for each member of any such component society whose dues in the State Society are paid April 1 of any current year.—*Pennsylvania Medical Journal,* January, 1932.

Deep Burns Caused by Roentgen Rays.—Deep burns caused by roentgen rays occur much too frequently and the danger of causing such burns should be stressed rather than minimized. The destructive powers of roentgen rays and radium are very great and must be considered as well as their curative powers. There is no question that, therapeutically at least, these agents should be used only by experts and even then with the utmost caution. Early and wide excision of deep burns caused by roentgen rays or radium, with closure of the defect thus made, by tissue shifting, promises more surely than any other method yet devised the elimination of pain, an excellent prospect of permanent healing and in many instances the restoration of function and, in addition, gives a reasonable assurance of safety from subsequent malignant degeneration.—*Journal of American Medical Association.*